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CC-FORM-3

USE FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA OCCURRING ON OR AFTER FEBRUARY 1, 2014

Send original and 4 copies to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

FILED
DEC 30 2019
8 WORKERS' COMPENSATION COMMISSION

Full Name of Claimant (Injured Employee) Brandon Wichert	Please check appropriate box ☑ I. Original Filing
Name of Employer Re-View Windows, Inc.	☐ II. Amends Previously Filed CC-Form-3. (Highlight the change and identify whether it adds to or replaces the prior Information.)
Commission Use Only Argonaut Ins	

EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

NOTE: Mediation is available to help resolve certain workers' compensation disputes.
For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.
(Please type or print)

COMMISSION FILE NO. 2019 08128 Q

FULL NAME OF EMPLOYEE (Last, First, Middle): Wichert, Brandon		Social Security Number (LAST 5 DIGITS ONLY): XXX-X 88880		Phone: (405) 938-6125
Mailing Address (include City, State & Zip): 6712 Bayberry Dr. Okc, OK 73162		Date of Birth: 01/19/1989	Age: 30	Sex: Male
Occupation: Installer	Was your employment agreement in Oklahoma? YES NO	Avg. Weekly Wage: Max	Length of Employment: Years 1 Months ___ Date of Hire:	
Date of Accident/Injury 5/15/2019	Injury resulted from: Single Incident X Cumulative Trauma		Time Injury Occurred ___ AM PM	
Describe parts of the body injured or affected Jaw, Cheek bone, Eye, Head, Neck, Back, L/Shoulder		Place of Injury: City/County/State Nashville, Davidson County, TN		
What is the nature of the Injury or Illness: unknown	Describe with details how the injury occurred. Include object or substance which directly injured you: MVA: clmt was passenger in company vehicle when 3rd party ran light			

Have you filed a claim for Social Security Disability Insurance Benefits? YES NO X

Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Claim for Compensation? YES NO X

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? ____. If so, you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund (MITF). A claim against the MITF is commenced by filing a "CC-Form-3F" with the Workers' Compensation Commission.

Treating Physician (full name):	Address:	City:	State:	Zip:
Employer: Re-View Windows, Inc.	Employer's FEI # (Federal ID Number):		Telephone: 816-741-2876	
Complete Mailing Address: 1235 Saline St.		City: N. Kansas City,	State: MO	Zip: 64116
Complete Street Address (if different from above):		City:	State:	Zip:

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

CLAIM INFORMATION (Please Print)

Is this a claim for **initial** benefits (i.e. no benefits, either medical or indemnity, have been received)? YES X NO

Is this a claim for **additional** benefits (e.g. additional temporary total disability, additional medical)? X YES NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:

Name of claimant's attorney if represented:

Type or Print Name of Attorney: Charles T. Simons	OBA# 17762	
Mailing Address: 4323 N.W. 63rd St., #110		
City Oklahoma City	State OK	Zip 73116
Telephone #: (405) 528-4567		

NOTICE: Pursuant to 85A O.S. §118, a fee of One Hundred Forty Dollars ($140.00) shall be collected by the Workers' Compensation Commission and assessed as costs to be paid by the party against whom any award becomes final.

The undersigned declare under PENALTY OF PERJURY that they have examined this *Employee's First Notice of Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this 27th day of December, 2019.

Signature of Claimant (must be signed by Claimant)

Signature of Attorney for Claimant (if any)

Revised 4-18-18

EXHIBIT "3"